

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 13 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34057**
Registrar's No. **8707**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME **Barbara Jean Dell**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **July 24 1948**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 10 hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business.....

MOTHER FATHER { 12. Name **Gerald Dell**
13. Birthplace **Corning Arkansas**
(City, town, or county) (State or foreign country)
14. Maiden name **Irene Wertenberger**
15. Birthplace **Corning Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gerald Dell**
(b) Address **919 St. Louis Avenue**
17. (a) **Burial** (b) Date thereof **10/7/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Laurel Hill Gardens**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.,**
OCT 6 1948 (b) **J. B. Leater**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **919 St. Louis Avenue.,**
26 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **4**
year **1948** hour **9:55** minute **A** M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Broncho Pneumonia
Primary
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)
(b) Means of injury.....
23. Signature **Frank E. Taylor, Dep. Cor.** (M. D. or other)
Address **1500 Clear St.** Date signed **10-6-48**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed W W Wilkinson
Licensed Embalmer No. 3575
P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.